Early Development Network Referral Form

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

NOTE: Each child under the age of 3 in a substantiated Child Abuse/Neglect case must be referred to early intervention services through the Early Development Network within two (2) working days after a Status Determination has been made.

Date: _____

Child's Name _____

DOB _____ Gender: ❑ Female ❑ Male

Child's Medicaid Number _____

Child's Current Address _____ Phone Number _____

Is child placed with _____ Parent _____ Foster Parent _____ Other _____

Parent/Guardian Name _____

Address _____ Phone Number _____

Parent/Guardian's Employer Telephone Number (optional) _____

Child's Doctor's Name _____ Dr's Phone Number _____

Case Worker Name _____ Phone Number _____

Supervisor's Name _____ Phone Number _____

Any developmental concerns: ❑ yes ❑ no If yes, please explain

Any medical concerns: ❑ yes ❑ no If yes, please explain

Additional comments:

Are parents aware of this referral to the Early Development Network? ❑ yes ❑ no

What was their response? _____

Worker's Signature _____ Date _____

ACTION TAKEN ON THIS REFERRAL

_____

_____

_____

_____

_____

Receiving Party's Signature _____ Date _____

Title _____ Phone Number _____

White: Case worker after completion by EDN - Yellow: Early Development Network - Pink: File copy

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